Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Monegas Care Home and Expanded ARCH	**CHAPTER 100.1**
Address: **94-913 Kuhaulua Street, Waipahu, Hawaii, 96797**	**Inspection Date: March 29, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Household Member (HHM) #1 – No record of initial positive tuberculosis (TB) skin test and subsequent negative chest x-ray. HHM#2 – No record of initial positive TB skin test available for review. HHM#3 – No record of initial positive TB skin test available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - For Household # 1 and 2 & called the Lanakila Health center to E-mail me the PPD test reading, provided PPD result HHM#1 11/04/2009 HHM#2 11/04/2009 Chest X-ray HHM#1 3/5/2019 HHM#2 3/5/2019 - For Household # 3 PPD skin test - 3/22/1996 Chest X-ray - 3/4/1997	4/18/2019

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Substitute Care Giver (SCG) #1 - No record of Primary Care Giver (PCG) training available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - A trained my substitute caregiver how to provide for the following skills - ~~Routine~~ Personal care skill - Elimination - Nutrition - Mobility - Infection control - Medical - Psychological Be passed for the training	4/1/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** The following medications ordered on 6/8/18 were not reevaluated and signed by physician within four months: • Propranolol 40mg by mouth twice daily • Aspirin DR 81mg by mouth daily • Atorvastatin 80mg by mouth daily	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** I notified his Primary Care Physician to updated his medication in his Physician Record thru telephone call and countersign for his next visit	4/1/2019

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☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** The following medications ordered on 6/8/18 were not reevaluated and signed by physician within four months: • Propranolol 40mg by mouth twice daily • Aspirin DR 81mg by mouth daily • Atorvastatin 80mg by mouth daily	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - In the future I shall asked to re-evaluated all his medication ordered and signed every four month by his Primary care Physician on APRN. - In the future I shall have a care team notebook and a calendar to note the month when to update his ordered medication and asked my substitute care given to review together the chart of my resident monthly.	5/29/19

Licensee's/Administrator's Signature: Brenda Magno Monegas

Print Name: BRENDA MAGNO MONEGAS

Date: 4/23/19

Licensee's/Administrator's Signature: Brenda Magno Monegas

Print Name: BRENDA MAGNO MONEGAS

Date: 5/29/19

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